

ACCIDENTS, INCIDENTS & EMPLOYEE SAFETY CONCERNS:
CLASSIFICATION & INVESTIGATION

Comments and questions regarding this policy should be directed to the contact person listed below:

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Address: G40 TASF
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Sign-off Record:

Approved by: _____ **Date:** _____
Manager, Environment, Safety, Health & Assurance

Reviewed by: _____ **Date:** _____
Deputy Director

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1.0 REVISION/REVIEW LOG

Environment, Safety, Health & Assurance (ESH&A) will review this document once every three years at a minimum:

<u>Revision Number</u>	<u>Effective Date</u>	<u>Contact Person</u>	<u>Pages Affected</u>	<u>Description of Revision</u>
0	9/1/1998	J. Withers	All	Initial Issue
1	11/1/2001	S. Nelson	All	G:\Docs&Recs\DCP\ Revisions Descriptions\102_038rev1
2	3/1/2002	S. Nelson	Page 6	G:\Docs&Recs\DCP\ Revisions Descriptions\102_038rev2

2.0 PURPOSE AND SCOPE

The primary purpose of investigating accidents and incidents is to determine what caused the event. By determining the direct, contributing, and root causes, corrective actions can be identified and similar occurrences prevented.

An effective Employee Safety Concerns Program is a key component of an organization's overall environment, safety and health program. Thorough investigation of employee concerns promotes "ownership" of the ES&H program by employees and contributes to the Lab's overall mission of providing a safe and health workplace while also protecting the environment.

Results of investigations also provide the basis for compliance with Department of Energy reporting requirements that include the Occurrence Reporting and Processing System (ORPS) and Computerized Accident & Incident Investigation Reporting System (CAIRS). Occupational Safety & Health Administration (OSHA) reporting requirements are fulfilled via completion of the OSHA 101 and 200 forms.

Information gleaned as a result of investigations is disseminated via the Laboratory's Lessons Learned Program (See Plan #10200.010, Lessons Learned Program Implementation Plan) as appropriate.

This procedure describes how the Laboratory investigates a work-related accident or incident. The process by which employee safety concerns are investigated is also described. It applies to all Ames Laboratory employees.

3.0 RESPONSIBILITIES

3.1 LABORATORY DIRECTOR – The Laboratory Director is ultimately responsible for ensuring that investigations of accidents & incidents are conducted in a comprehensive and timely fashion; the Director is also responsible for fostering an environment in which employee safety concerns are shared and addressed.

- 3.2 PROGRAM DIRECTOR / DEPARTMENT MANAGER – Program Directors and Department Managers shall work closely with ESH&A and DOE personnel on accident investigations as required; Program Directors and Department Managers shall also ensure that program personnel are encouraged to share concerns and that those concerns will be resolved in a timely manner by working with appropriate Laboratory personnel.
- 3.3 GROUP / SECTION LEADER – Group/ Section Leaders shall ensure that group members report all work-related injuries and illnesses to their immediate supervisor and seek medical assistance from the Occupational Medicine office, if necessary; Group / Section Leaders shall encourage the sharing of concerns by employees and participate with appropriate Laboratory personnel in their resolution.
- 3.4 ENVIRONMENT, SAFETY, HEALTH & ASSURANCE (ESH&A) – ESH&A will facilitate the implementation of this procedure by working with appropriate Laboratory personnel; ESH&A will also be responsible for classifying accidents (including the Occurrence Reporting and Processing System (ORPS)), conducting accident investigations as indicated by this procedure, recommending corrective actions and assuring that all required recordkeeping is completed; ESH&A will also serve as the primary contact for any external investigations conducted by DOE.
- 3.5 OCCUPATIONAL MEDICINE – Occupational Medicine shall be responsible for treatment or referral of all work-related injuries and illnesses; Occupational Medicine shall also interact with ESH&A on the investigation and classification of incidents and accidents.
- 3.6 EMPLOYEES – Ames Laboratory employees shall facilitate the implementation of this procedure by participating in investigations, sharing concerns pertaining to workplace safety and health and the environment with their supervisor, and complying with all relevant ES&H policies and procedures.

4.0 ACCIDENT & INCIDENT INVESTIGATION AND CLASSIFICATION PROCEDURES

4.1 DOCUMENTATION

Occupational Medicine and/or ESH&A shall evaluate all reported work-related accidents and incidents. The Investigation & Recordkeeping Process Form # 10200.128 (Appendix A) shows the process that is followed. The following documentation is filled out when a medical evaluation is done after a work-related accident or incident:

- 1) **Patient Status Report** – Form # 10200.129 (Appendix B) – This form is filled out by the Occupational Medicine physician and details the diagnosis and any work restrictions. The original is kept in the employee's medical records; copies are sent to the employee, supervisor and Beardshear.

- 2) **U.S. DOE Supplementary Record of Occupational Injuries & Illnesses** Form #10200.130 (Appendix C) – This form is completed by the patient and supervisor and returned to Occupational Medicine. Occupational Medicine routes the form to ESH&A for review. ESH&A conducts any necessary investigations, determines number of days away from work and number of days of restricted work activity and returns the form to Occupational Medicine after a signature from the ESH&A Manager. ESH&A retains the original and sends two copies to Occupational Medicine. On a regular basis, the Occupational Medicine Coordinator, Industrial Safety Specialist and Industrial Hygienist confer on the status of each work-related incident. Upon mutual consent, incidents are classified as OSHA-recordable or non-recordable.
- 3) **Work-Related Injury Report** Form 46600.024 (Appendix D) – This form is filled out by Occupational Medicine and delivered to ESH&A immediately upon completion of treatment of a work-related injury.
- 4) **Incident and Concern Reporting** Form #10200.088 (Appendix E) – This form is initiated by either the employee raising the concern or ESH&A and later completed by the ESH&A lead assigned to track the concern.
- 5) **State of Iowa First Report of Injury or Illness** Form 10200.131 (Appendix F) – This form is filled out and sent to 1350 Beardshear Hall, ISU for further processing.

4.2 INVESTIGATION, CLASSIFICATION & REPORTING

All accident investigations and reporting will be conducted in accordance with Procedure #40000.001: *Ames Laboratory Occurrence Reporting and Processing Implementation Plan*. Table 1 (page 8) – “Accident/Incident Classification and Associated Notifications and Reviews” summarizes accident/incident classification and associated notifications and reviews. A brief summary is also provided below:

4.2.1 CLASSIFICATION

Four classes of accidents or incidents have been established at Ames Laboratory:

- **Class I** – Accidents of highest severity, with the greatest impact on or damage to Laboratory programs, operations or personnel (e.g. fatality, permanent total disability, property damage greater than 2.5M, etc.).
- **Class II** - Accidents of high severity, with high impact on or damage to Laboratory programs, operations or personnel (e.g., occupational illness that requires in-patient hospitalization, property damage \geq \$1M but $<$ \$2.5M, etc.).
- **Class III** - Accidents of moderate severity, with moderate impact on or damage to Laboratory programs, operations or personnel (e.g., recordable injury or illness, property damage \geq \$5000 but $<$ \$1M, etc.).
- **Class IV** - Accidents of minor severity, with minor impact on or damage to Laboratory programs, operations or personnel (e.g. first aid injuries) and incidents.

4.2.2 INVESTIGATION

Class I accidents require a Type A investigation by a board appointed and managed by the Office of the Assistant Secretary for Environment, Safety and Health in accordance with DOE O 225.1A.

Class II accidents require a Type B investigation by a board appointed and managed at the Field Level in accordance with DOE O 225.1A.

All Class III accidents shall be conducted in accordance with established accident investigation procedures by Ames Laboratory personnel including ESH&A specialists with training on accident investigation principles.

Class IV incidents will be conducted informally and include research and ESH&A personnel. A graded approach shall be applied to Class III & IV investigations taking into account the severity and nature of the accident or incident.

Ames Laboratory shall establish and maintain readiness to respond to accidents, mitigate the consequences, collect and preserving evidence to conduct the investigation. This readiness shall include preserving the accident scene to the extent that is possible, documenting the accident scene through photography and other means.

Ames Laboratory shall also prepare, implement and track to completion approved corrective action plans that satisfy judgments of need identified through the investigation.

4.2.3 REPORTING & NOTIFICATION

The Laboratory Director, Iowa Occupational Safety & Health and the Ames Area Office – Chicago are notified of all Class I accidents; the Laboratory Director and the Ames Area Office – Chicago are notified of all Class II accidents.

ORPS and CAIRS reports are filed.

CAIRS reports are filed for all Class III accidents and incidents.

Affected research groups are notified of Class IV accidents and incidents.

4.3 EMPLOYEE SAFETY CONCERNS PROGRAM

ESH&A shall document employee concerns utilizing the Incident and Concern Reporting Form 10200.088 (Appendix E). These forms may also be filled out by employees upon request. Instructions for filling out the forms are as follows:

Date: Date of occurrence/concern.

Time: Time of concern or when report is filed.

Name: Fill in your name.

Bldg./Room: Fill in building and room where concern is located.

Phone: - Fill in your phone number.

ESH&A Point-of-Contact: Name of ESH&A person who received information or was assigned to follow up on issue.

Ames Laboratory
Office: Environment, Safety, Health & Assurance
Title: Accidents, Incidents & Employee Safety Concerns:
Classification & Investigation

Procedure: 10200.038
Revision: 2
Effective Date: 3/1/02

Page: 7 of 8

Review Date: 3/1/2005

Nature of Incident/Concern - Briefly describe the nature of the concern including time of discovery, any actions taken upon learning of the concerns and previous reporting.

(Form is forwarded to Industrial Safety Specialist at G40 TASF for processing/classification)

Classification: Incident/concern will be classified by ESH&A in accordance with the definitions in Table 1. All concerns that don't involve personal injury or any of the other components listed will be classified as Class IV.

Root Causal Determination: Upon completion of the investigation, a root causal determination will be defined for each concern.

Comments: Additional comments pertinent to the concern will be added.

Area of Concern: The concern will be classified in one of the major topical areas listed.

Number: ____ - ____: Each concern will be given a unique number that will correspond to the year and be assigned a sequential number (e.g., 01-001, 01-002, 01-003, etc.)

Acknowledge date: Number of days from point of notification to ESH&A notification of the affected party.

Address date: Number of days from point of notification to concern being formally addressed by ESH&A or other Laboratory entity.

Each concern will be thoroughly evaluated by an ESH&A Specialist. The form shall serve as the mechanism by which documentation of events shall occur. Any supporting documentation will be attached to the form for future reference.

All new employees receive introductory information describing the Employee Safety Concerns Program in General Employee Training (required). Program information is made available to employees on a periodic basis via lab-wide announcements (e.g. *Insider*).

4.4 LESSONS LEARNED PROGRAM

Depending on the nature of the incident or accident, the Ames Laboratory Lessons Learned Program may disseminate information from an investigation. A detailed description of the Lessons Learned Program can be found in plan #10200.010: *Ames Laboratory Lessons Learned Implementation Plan*.

4.5 OCCURRENCE REPORTING

Depending on the nature of the incident or accident, a report may be submitted to the DOE Occurrence Reporting and Processing System. For a detailed summary of ORPS, the reader is referred to DOE Order 232.1A and summary information in the ESH&A office.

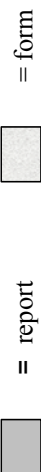
4.6 COMPUTERIZED ACCIDENT & INCIDENT INVESTIGATION REPORTING SYSTEM (CAIRS)

Depending on the nature of the incident or accident, a report may be submitted to the DOE Computerized Accident & Incident Investigation Reporting System (CAIRS). For a detailed summary of CAIRS, consult information in the ESH&A office.

**TABLE 1 - ACCIDENT/INCIDENT CLASSIFICATION
AND ASSOCIATED NOTIFICATIONS AND REVIEWS**

CLASS	ACCIDENT	NOTIFICATION	INVESTIGATION OFFICE	MANAGEMENT REVIEW
I	Fatality; 1 incident involving hospitalization of three or more individuals; Permanent total disability; Property damage —\$2.5M; Environmental release — 5x reportable quantities with significant off-site effects; Loss/theft of radioactive material that may present a health hazard to the public; Rad exp — 25 rem TEDE; 75 rem eye; 250 rem extremity, organ or skin; 2.5 rem to fetus; Release of radioactivity — 5000 X concentration guides	Lab Director IOSH Ames Area Office – CH ORPS CAIRS	DOE – CH (Type A)	DOE – CH
II	Incident with hospitalization of 1 or more individuals for more than 5 continuous days; Property damage — \$1M and < \$2.5M; Radiation exposure: 10 rem ... whole body < 25 rem; 30 rem ... eye < 75 rem; 100 rem ... organ/extremity/skin < 250 rem; 1 rem ... fetus < 2.5 rem; Release of hazardous material — 2 times but ... 5 times the reportable quantities, that results in serious environmental damage	Lab Director Ames Area Office – CH ORPS CAIRS	DOE – CH (Type B)	DOE – CH
III	Recordable injury with lost/restricted work days; Recordable injury without lost/restricted work days; Occupational illness; Property damage <\$1M —\$5000; Vehicle damage —\$1000; Environmental release — reportable quantities	CAIRS	Ames Laboratory	Ames Laboratory
IV	Non-recordable injuries (first aid); Near misses	Research Group	Research Group Ames Laboratory	Research Group Ames Laboratory

Form # 10200.128 Rev 0



Appendix B

Iowa State University/Ames Laboratory

Occupational Medicine
Ames, Iowa 50011-3020

515 294-2056
FAX 515 294-1967

PATIENT STATUS REPORT

Time in _____ Time out _____

Patient: _____	Date seen: _____
Diagnosis: _____	Date injured: _____

- | | |
|--|---|
| <input type="checkbox"/> Unable to perform any work
<input type="checkbox"/> Fit for full duty on _____
<input type="checkbox"/> Fit for modified duty* on _____ | <input type="checkbox"/> Anticipated return to work
Full duty _____
Modified duty _____ |
|--|---|

Work Related: ☐ Yes ☐ No ☐ Undetermined
Work Restrictions:

Comments:

- ☐ No lifting over _____ lbs.
- ☐ Avoid repetitive bending and twisting.
- ☐ No overhead work.
- ☐ Sit down duties only.
- ☐ Standing and walking as tolerated.
- ☐ No use of _____
- ☐ No repetitive or forceful gripping, pinching, or wrist motions
 with hand: ☐ R ☐ L ☐ Both
- ☐ Keep wound clean and dry.
- ☐ No overtime work.
- ☐ Keep splint on _____
- ☐ No driving or operating dangerous equipment.
- ☐ No kneeling or squatting.
- ☐ Limit keyboard use to _____
- ☐ Avoid exposure to _____
- ☐ No pushing or pulling.

* If work that satisfies the above limitations cannot be provided,
the patient is not to work and should return as scheduled.

Medication _____

Physical Therapy _____

- ☐ To return to clinic in _____ days, weeks, months Date _____ Time _____ am/pm
- ☐ Referred to _____

☐ Discharged from treatment on _____ Steven R. Sheldahl, M.D.

☐ No permanent impairment anticipated. ****Patient's Signature** _____

**** Patient instructions given and patient verbalizes understanding of same. ****

White: Occupational Medicine copy Yellow: Patient copy Pink: Supervisor copy Gold: Administration copy psr 8/96

Appendix C

DOE F 5484.3
(8-80)
DOE 5484.1

U.S. Department Of Energy

Case or File No. _____

Supplementary Record Of Occupational Injuries And Illnesses

EMPLOYER: Ames Laboratory, Iowa State University, Ames, Iowa 50011

INJURED OR ILL EMPLOYEE

1. Name _____ Social Security No: _____
 (First Name) (Middle Name) (Last Name)

2. Home Address _____
 (No. & Street) (City/Town) (State/Zip)

3. Age _____ 4. Gender: Male _____ Female _____ (Check One)

5. Occupation _____ Ames Lab Employee #: _____
 (Enter regular job title, not the specific activity employee was performing at time of injury.)

6. Department _____
 (Enter name of department or division in which the injured person is regularly employed, even though employee may have been temporarily working in another department at the time of injury.)

THE ACCIDENT OR EXPOSURE TO OCCUPATIONAL ILLNESS

7. Place of accident or exposure _____
 (No. & Street) (City/Town) (State/Zip)

8. Was place of accident or exposure on employer's premises? Yes _____ No _____

9. What was the employee doing when injured? (Be specific. If he/she was using tools or equipment or handling materials, name them and tell what he/she was doing with them.)

10. How did the accident occur? (Describe fully the events which resulted in the injury or occupational illness. Tell what happened and how it happened. Name any object or substance involved and tell how it was involved. Give full details on all factors which led or contributed to the accident. Use separate sheet if additional space is needed.)

11. Describe the injury or illness in detail and indicate the part of body affected. (e.g., amputation of right index finger at second joint; fracture of ribs; lead poisoning; dermatitis of left hand, etc.)

12. Name the object or substance which directly injured the employee. (For example, the machine or thing employee struck against or which struck the employee; the vapor or poison inhaled or swallowed; the chemical or radiation which irritated employee's skin; or in cases of strains, hemias, etc., the thing employee was lifting, pulling, etc.)

13. Date and time of injury or initial diagnosis of occupational illness _____

14. Did the employee die? Yes _____ No _____

OTHER

15. Name and address of physician _____

16. If hospitalized, name and address of hospital _____

Prepared By _____ Date of Report _____
 Reviewed By _____ (Supervisor)
 Reviewed By _____ (Group Leader)

C:\MS PUB\INJURY.PUB

Appendix D

To: ESH&A
G40 Staff

From: Occupational Medicine
G11 TASF

Subject: **Work Related Injury Report**

Employee's Name: _____

Location of Incident: _____

Injury: _____

Date and time of incident: _____

Occupational Medicine Signature

Date

Appendix E

INCIDENT & CONCERN REPORTING FORM

Date: _____ **Time:** _____

☐ Per employee notification to ESH&A (Attach any documentation).

☐ Per Occupational Medicine Report (Attach documentation).

Name: _____ **Bldg./Room:** _____ **Phone:** _____

ESH&A Point-of-Contact: _____

Nature of Incident / Concern *(Include a discussion of investigation and resolution of event):*

(Forward to Industrial Safety Specialist at G40 TASF)

Classification: ☐ Type I ☐ Type II ☐ Type III ☐ Type IV (Concern)

Root Causal Determination

Comments:

Area of Concern:	<input type="checkbox"/> Electrical Safety	<input type="checkbox"/> Fire Safety	<input type="checkbox"/> Egress Path	<input type="checkbox"/> Industrial Hygiene
	<input type="checkbox"/> Health Physics	<input type="checkbox"/> Cylinders/gas	<input type="checkbox"/> Industrial Safety	<input type="checkbox"/> Waste Management
	<input type="checkbox"/> Emissions & P2	<input type="checkbox"/> Hoisting/rigging	<input type="checkbox"/> Property Management	<input type="checkbox"/> Housekeeping
	<input type="checkbox"/> General Safety	<input type="checkbox"/> Other: _____		

Number: ____ - ____ (e.g., 01- 001, 01-002, 01-003, etc.)

Acknowledge date: _____ (# days ____)

Address Date: _____ (# days ____)

(Forward to Employee Concerns File and Enter into CA5 Database)

Appendix F

Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS Jurisdiction Code: _____ Jurisdiction Claim Number _____

Send completed form to: Risk Management, Rm 1350 Beardshear Hall, ISU FAX (515)294-1621 PHONE 294-7711

CLAIM ADMN	1. Claim Administrator Name: SEDGWICK CLAIMS MANAGEMENT SERVICES		3. Claim Representative Business Phone No.: (515) 327-4888		6. Insurer Name (if different than claim administrator): IOWA -- STATE OF		
	2. Mailing Address, City, State, & Postal Code: 12119 STRATFORD DRIVE CLIVE, IA 50325-8146		4. Claim Administrator Claim No.:		7. Insurer FEIN: 420932069		
EMPLOYER	9. Employer Name: IOWA -- STATE OF		12. Employer FEIN: 420932069		14. Insured Report No.:		
	10. Physical Address, City, State, & Postal Code 400 E 14 TH STREET DES MOINES, IA 50319-9001		13. Mailing Address, City, State & postal Code: 400 E 14 TH STREET DES MOINES, IOWA		15. Industry Code:		
	11. Nature of Business: GOVERNMENT		19. Employer Contact Name and Business Phone Number: Joni Ward, Risk Management, Iowa State University 515-294-7083 (William West IDOP 515-281-3360)				
	16. Insured Location No.:		18. Employer UI No.:				
PO	20. Insured Name (parent company if different from employer):		21. Insured FEIN:		22. Insured Postal Code:		
	23. Policy/Contract No. :		24. Coverage Effective		26. Self Insurance License/Certificate		
EMPLOYEE	27. Employee Name (First, Middle, Last, & Suffix):		33. Date of Birth: / /		36. Gender <input type="checkbox"/> Male(M) <input type="checkbox"/> Female(F)		
	28. Residential Mailing Address: Street/PO Box: City: State: Postal Code:		34. Date of Hire: / /		37. Educational Level: N/A		
	29. Phone Number (include area code): ()		35. Employment Status (check one): <input type="checkbox"/> Piece Worker <input type="checkbox"/> Volunteer <input type="checkbox"/> Seasonal <input type="checkbox"/> Apprenticeship/FT <input type="checkbox"/> Apprenticeship/PT <input type="checkbox"/> Regular Employee/FT <input type="checkbox"/> Regular Employee/PT <input type="checkbox"/> Other		38. Tax Filing Status (check one): <input type="checkbox"/> Single (A) <input type="checkbox"/> Single/Head of Household (B) <input type="checkbox"/> Married/Filing Joint (C) <input type="checkbox"/> Married/Filing Separate (D)		
	30. Occupation Description:		39. Employee ID No.: ID#: (check one) <input type="checkbox"/> Social Security No. <input type="checkbox"/> Employment VISA No. <input type="checkbox"/> Passport No. <input type="checkbox"/> Green Card <input type="checkbox"/> Employee ID Assigned		40. Marital Status (check one): <input type="checkbox"/> Unmarried (U) <input type="checkbox"/> Married (M) <input type="checkbox"/> Separated (S)		
	31. Manual Classification Code:		41. Employee's Authorization to Release the Following: Medical Records <input type="checkbox"/> YES <input type="checkbox"/> NO Social Security Number <input type="checkbox"/> YES <input type="checkbox"/> NO				
	32. Department Where Regularly Worked:						
	42. Average Wage \$ (check one): <input type="checkbox"/> hourly <input type="checkbox"/> daily <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> semi-monthly <input type="checkbox"/> monthly <input type="checkbox"/> annual		44. Salary Continued in Lieu of Compensation: <input type="checkbox"/> YES <input type="checkbox"/> NO		47. Employee Number of Dependents:		
43. Number of Days Regularly Worked Per Week:		45. Full Wages Paid for Date of Injury: <input type="checkbox"/> YES <input type="checkbox"/> NO		48. Employee Number of Exemptions: _____ (check one) <input checked="" type="checkbox"/> Entitled <input type="checkbox"/> Withholding			
ACCIDENT ■ INJURY	49. / / Date of Injury		63. Describe the nature of the injury (ex. amputation, burn, cut, fracture):				
	50. / / Date Employer Had Knowledge of the Injury		64. Part(s) of body directly affected by the injury or illness (ex. hand, arm, circulatory system):				
	51. / / Date Administrator Had Knowledge of the Injury		65. Describe the events that caused the injury (ex. fell, operating machinery, chemical exposure):				
	52. / / Last Day Worked		66. Name the object or substance that directly injured the employee (ex. knife, floor, acid, oil):				
	53. / / Initial Return to Work Date (if applicable)		67. Specify activity the employee was engaged in when the event occurred (ex. cutting metal plate for flooring). Indicate if activity was part of normal duties:				
	54. / / Employee Date of Death (if applicable)		68. Witness Name and Business Phone Number: ()				
	55. : Time of Injury						
	56. : Time Employee Began Work						
MEDICAL	57. Pre-existing Disability Code: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown		70. Initial Medical Provider Name:				
	58. Accident Premises Code: <input type="checkbox"/> Employer (E) <input type="checkbox"/> Lessee (L) <input type="checkbox"/> Other (X)		71. Initial Medical Provider Physical Location Address: City: State: Postal Code:				
	59. Accident Site Organization Name: Iowa State University		72. Managed Care Organization Name or ID No.: N/A				
	60. Accident Site: Street: City: State: Iowa Zip:		73. ICD Primary Diagnostic Code (if known): N/A				
	61. Accident Location narrative (if no street address):						
62. Accident Site County/Parish:							
69. Initial Treatment Code (check one): <input type="checkbox"/> no medical treatment (0) <input type="checkbox"/> emergency care (3) <input type="checkbox"/> minor/on-site treatment (1) <input type="checkbox"/> hospitalization > 24 hours (4) <input type="checkbox"/> clinic/hospital visit (2)		74. Preparer's Name & Title (Supervisor)		75. Preparer's Department:		76. Preparer's Ph. Number: ()	
						77. Date:	